REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

286.2

A MANAGEMENT ANALYSIS OF THE THIRD PARTY LIABILITY AND OTHER HEALTH COVERAGE PROGRAMS

THE MEDI-CAL INTERMEDIARY OPERATIONS AND THE STATE DEPARTMENT OF BENEFIT PAYMENTS

MARCH 1977

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

MIKE CULLEN
CHAIRMAN

March 22, 1977

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's management analysis of the third-party liability and other health coverage programs intended to recover from liable third parties, Medi-Cal payments made by the State.

By copy of this letter, the Department is requested to advise the Joint Legislative Audit Committee within sixty days of the status of implementation of the recommendations of the Auditor General that are within the statutory authority of the Department.

The auditors are Kurt R. Sjoberg, Manager; B. L. Myers and Linda L. Huffman.

Respectfully submitted,

MIKE CULLEN
Chairman

SUITE 750 • 925 L STREET • SACRAMENTO 95814 • (916) 445-0255

TABLE OF CONTENTS

SUMMARY

The State of California's Third Party Liability and Other Health Coverage Programs are intended to recover Medi-Cal payments from liable third parties.

The Third Party Liability Unit of the Medi-Cal Intermediary Operations is required to identify and recover medical expenses paid on behalf of Medi-Cal beneficiaries who are injured by a third party. The Department of Benefit Payments' Health Recovery Bureau is required to identify Medi-Cal beneficiaries who have health insurance and bill the carrier when services are provided.

We found that:

- The inadequate reporting of third-party cases by county welfare departments and liability and workers' compensation insurance carriers, and the duplication of identification and recovery activity by the Third Party Liability Unit and the Health Recovery Bureau, result in additional Medi-Cal administrative costs and significant lost third-party recoveries (page 9).

  The Medi-Cal program is incurring losses due to inadequate procedures regarding recipients who have other health insurance. These inadequacies are

demonstrated at the county level by the lack of review procedures. At the state level, forms to record changes in insurance status are inadequate, as is the contract with the Social Security Administration (page 19).

The Department of Benefit Payments has estimated that the Medi-Cal program spent at least $26 million in fiscal year 1974–75 on services to beneficiaries who already had health insurance policies unknown to the Department. Since health insurance carriers are generally liable for only about 20 to 25 percent of the billed amount, an estimated minimum loss of $5 to $7 million results from inadequate identification of beneficiaries with health insurance.

These problems reduce the effectiveness of the program to recover Medi-Cal payments due from insurance companies and other responsible parties.

On pages 16 and 25 we recommend corrective action by the Departments of Health and Benefit Payments.

INTRODUCTION

In response to a resolution of the Joint Legislative Audit Committee and under the authority vested in the Auditor General by Section 10527 of the Government Code, we reviewed the administration of the Third Party Liability and Other Health Coverage Programs by the Medi-Cal Intermediary Operations and the Department of Benefit Payments. This is the second in a series of reports on Medi-Cal.*

Title XIX of the Social Security Act as amended in 1965 provides grants to states for medical assistance programs. The Title XIX program was established to pay for necessary medical services for eligible persons whose income and resources are insufficient to pay for their health care. The Federal Government shares the cost of providing medical assistance with the states, and in California the federal share of medical expenses is about 50 percent.

The U.S. Department of Health, Education and Welfare has overall responsibility for administering the Title XIX medical assistance program at the federal level. The Federal Government requires that a single state agency be responsible for all state government activities involving the administration of federally financed programs. California has designated the Department of Health as the single agency responsible for the California Medical Assistance (Medi-Cal) Program.

* See Costs and Revenues of the Medi-Cal Claims Processing Subcontract, (286.1), January 1977.

Effective July 1, 1974, California Assembly Bill 1950 (1973 Statutes, Chapter 1212) transferred the responsibility for Medi-Cal recovery from the Department of Health to the Department of Benefit Payments. The Department of Health now has overall responsibility for administering the Medi-Cal program, while the Department of Benefit Payments has responsibility for recovering amounts due the Medi-Cal program from third parties. The Department of Benefit Payments is responsible for recovering Medi-Cal payments made on behalf of Medi-Cal beneficiaries from health insurance carriers. The recovery of payments from third parties that have a tort* liability to a Medi-Cal beneficiary and workers' compensation insurance is the responsibility of the Medi-Cal Intermediary Operations.

Third-Party Liability

California has contracted with Medi-Cal Intermediary Operations (MIO) as fiscal intermediary to process most of the provider claims for the Medi-Cal program. MIO is a consolidation of the California Physicians' Service (Blue Shield), Hospital Service of California (Blue Cross North) and Hospital Service of Southern California (Blue Cross South) organized to process Medi-Cal claims.

* A private or civil wrongdoing, other than a breach of contract.

MIO's contractual responsibilities with the State include processing and paying claims of eligible providers at rates set by the State for services rendered to Medi-Cal beneficiaries. MIO is also responsible for identifying and recovering the medical expenses paid on behalf of Medi-Cal beneficiaries who were injured by or involved in an accident caused by a third party. The Third Party Liability Unit of MIO is responsible for identification and recovery.

Third-party cases may be directly referred to the Third Party Liability Unit by county welfare departments, agencies that are in contact with Medi-Cal beneficiaries, prepaid health plan organizations or a Medi-Cal beneficiary's attorney. In addition, third-party cases can be identified by matching those Medi-Cal diagnosis codes which indicate trauma, to payments made on behalf of Medi-Cal beneficiaries. A questionnaire is sent to such beneficiaries to determine if a third party was responsible for the injury.

The Third Party Liability Unit of MIO has a budgeted staff of 28 personnel and a 1976–77 operating budget of $362,000. As of June 30, 1976, the third party unit had over 11,000 cases representing potential recoveries of about $22 million. The unit recovered approximately $3.7 million during the 1975–76 fiscal year.

Insurance Recovery

State law establishes that Medi-Cal is not responsible for final payment of medical services provided to Medi-Cal beneficiaries if there are benefits available from insurance carriers such as privately paid insurance, employer-paid group plans, union or fraternal plans, Medicare or CHAMPUS.* The Health Recovery Bureau is responsible, through its Operations Section, for identifying Medi-Cal beneficiaries who have health insurance coverage, matching Medi-Cal provider payments to these beneficiaries and billing the insurance carriers for the Medi-Cal payments.

When a Medi-Cal beneficiary who has health insurance receives treatment, the provider may file a claim to be paid by Medi-Cal. The paid claim is then submitted by the Health Recovery Bureau to the insurance carrier for reimbursement. The provider may also claim payment directly from the insurance carrier. When this occurs, the provider can then submit a Medi-Cal claim for any difference between the carrier's payment and the prevailing Medi-Cal rate from Medi-Cal. Double payments can occur if an insurance company pays the Medi-Cal beneficiary directly and the provider has filed a Medi-Cal claim or if the provider files concurrent claims with Medi-Cal and a carrier. The Health Recovery Bureau is then responsible for recovering the duplicate payment from the beneficiary or provider.

* Civilian Health and Medical Program for the Uniformed Services.

The Bureau's Operations Section had a staff of 46 persons and an operating budget of $524,000 for fiscal year 1975–76. The section recovers about $2.2 million per year from approximately 93,000 payment demands to insurance carriers. In addition, the section identified over 25,000 Medi-Cal beneficiaries with health insurance during fiscal year 1975–76.

The Compliance Section had 24 positions with a budget of $272,000. This section is responsible for collecting payments due to Medi-Cal and certain locally administered programs. The section collected about $90,000 in third-party and about $85,000 in health insurance accounts receivable in fiscal year 1975–76. The third party and health insurance programs encompass only a small part of the section's overall responsibility. The broader range of operations of the Compliance Section will be discussed in detail in a subsequent report.

Scope of the Review

We reviewed the administration of these programs at state, county and intermediary offices. Our review included surveying a random sample of adult aid recipients, evaluating fiscal and program reports and interviewing state, local and intermediary officials.

Both the Third Party Liability Unit and the Health Recovery Bureau have implemented automated identification systems within the last year. These systems have not been operational for a sufficient time

to evaluate their total effect on their respective programs. However, these systems appear to be capable of providing a significant improvement in the identification of third-party cases and Medi-Cal beneficiaries with health insurance. In the following report, we have not taken exception to issues which recent changes in statutes or systems are designed to correct.

AUDIT RESULTS

INADEQUATE REGULATION OF THIRD-PARTY REFERRALS AND DUPLICATION OF EFFORT IMPEDE IDENTIFICATION AND RECOVERY OF MEDI-CAL PAYMENTS

Section 14124.71 of the Welfare and Institutions Code specifies that Medi-Cal payments are to be recovered from liable third parties who have caused injuries to Medi-Cal beneficiaries. The Third Party Liability Unit of the Medi-Cal Intermediary Operations is responsible for identifying third-party cases and recovering any related Medi-Cal payments from the third party.

Rather than attempt to collect directly from the third party, the California Administrative Code* requires that Medi-Cal payments be recovered from the third party's settlement. The process for recovering the Medi-Cal payments involves discovering when a third-party-caused injury takes place and collecting the amount of the Medi-Cal payment from the settlement monies received by the beneficiary.

The following weaknesses exist in the identification of third-party cases and the recovery of Medi-Cal payments:

- Due to inadequate state regulations, county welfare departments do not consistently refer known third-party cases. In addition, settlements made out of court by

* Title 22, Section 50771.

insurance carriers and through Workers' Compensation Insurance may not be brought to the attention of the third party unit on a timely basis.

- The lack of an MIO field staff decreases recoveries and increases recovery costs.

The Referrals of Known Third-Party Cases Are Not Adequately Regulated

The MIO Third Party Liability Unit implemented an expanded computer process to identify potential third-party cases in September 1976. Medi-Cal provider claims include injury-related Medi-Cal diagnosis codes. When such codes are identified, inquiries are sent to the Medi-Cal beneficiary requesting details of the cause of the injury including the name of any responsible third party. This process is the primary method for identifying third-party cases.

There are instances, however, when third-party cases could be identified before the provider claim is paid. County welfare departments, prepaid health plans, third-party insurers, Medi-Cal beneficiaries' attorneys, the State Compensation Insurance Fund and the Workers' Compensation Appeals Board all have early contact with Medi-Cal beneficiaries with third-party-caused injuries. Of these, only county welfare departments and attorneys for Medi-Cal beneficiaries are required to notify the third party unit of potential third-party cases. Department of Health officials advise that revisions to the contract

between the Department and prepaid health plans include requirements to report treatment of a third-party-caused injury. These contract revisions became effective on February 28, 1977.

County welfare department eligibility workers become aware of the injured party when an application for Medi-Cal is made to help pay for the medical costs incurred during treatment for the third-party-caused injury. Referrals from the counties in these cases could identify the third-party case sooner than the match of the trauma code and claims paid file. As a result, the third party unit could establish a file on the case prior to the settlement of any third-party suit.

The California Administrative Code* requires that each county welfare department report knowledge of any third-party case and any other eligibility information to the Department of Health. These reports are due monthly; however, the regulation does not require reporting at the time a third-party case comes to the county's attention. Despite this absence of regulations, eight of nine counties we reviewed were making third-party referrals when information became available. However, four of the counties were sending the information to the Health Recovery Bureau field offices while the four other counties were sending the information to the Health Recovery Bureau headquarters office in Sacramento. None of the counties were sending the information directly to the Third Party Liability Unit which is responsible for such recoveries. Department of Benefit Payments officials have stated that instructions

* Title 22, Section 50771.

are being drafted to require the county welfare departments to report directly to the third party unit.

A third-party liability case may also be settled by directly paying a beneficiary through the third party's insurer or through workers' compensation insurance. The only party then required to report to the third party unit is the beneficiary. However, the third party unit may not become aware of the case until the paid provider's claim is matched to the Medi-Cal trauma code file. By this time, case review has shown that some beneficiaries have spent the settlement, thereby leaving Medi-Cal with little chance of recovery. The beneficiary is not penalized, however, if no report is made.

Finally, Department officials state that injuries occurring on the job could be reported to the third party unit if the workers' compensation carriers were to indicate that the injured party was a Medi-Cal beneficiary.

The total loss to Medi-Cal resulting from the untimely identification of third-party cases is unknown. However, through discussions with Department of Benefit Payments personnel and review of case files, we did find examples of significant losses. Prior to January 1, 1977, the State had one year from the date of settlement to recover third-party liabilities (Code of Civil Procedure, Section 340). We examined cases in which the statute of limitations had elapsed prior to the third

party unit's becoming aware of a settlement. In one such case, over $10,000 had been paid by Medi-Cal but no collection could be made from a reported $70,000 settlement. In another case, about $2,700 had been paid by Medi-Cal but no amount was collected from the $15,000 settlement. Department officials state that "several hundred" cases will have to be closed because the statute of limitations has elapsed. Effective January 1, 1977, the Code of Civil Procedure (Section 338) provides for a three-year limitation period. While this gives Medi-Cal more time to recover payments, recovery will still be thwarted if the beneficiary relocates soon after a settlement is made. Timely notification of third-party cases would permit pursuit and collection of Medi-Cal payments at the time of the settlement.

The Lack of Field Staff
in the Third Party Liability Unit
Decreases Medi-Cal Recoveries
and Adds to Recovery Costs

The Third Party Liability Unit of MIO does not have field offices. Therefore, when it is necessary to make direct contact with a Medi-Cal beneficiary to identify a responsible third party or to recover Medi-Cal payments from a third-party settlement, the Department of Benefit Payments provides the field office services.

After the third party unit matches the claims paid file and the diagnosis code file, the Medi-Cal beneficiary is sent an inquiry requesting information to identify the third party. After two unsuccessful attempts to obtain a response, the third party unit then sends the case file to the

headquarters office of the Department of Benefit Payments' Health Recovery Bureau or the responsible county welfare department. The information sent to the Health Recovery Bureau is forwarded to the field office in the appropriate geographic area. The field office or county welfare department personnel then attempt to contact the beneficiary to obtain the information necessary to determine if there was third-party involvement. The case file is returned to the third party unit when this is complete. About 7,000 third-party cases, or 19 percent of the total third-party caseload, are processed by the Health Recovery Bureau's field offices or the county welfare departments.

Later, when a third-party settlement is made with a Medi-Cal beneficiary, the third party unit is responsible for recovering the Medi-Cal payments made on the beneficiary's behalf. Lack of a field staff limits the third party unit's collection effort to mailing a demand for payment to the beneficiary. Any follow-up to enforce collection is done by the Health Recovery Bureau after the case is referred back by the third party unit. The Health Recovery Bureau collects about $90,000 per year, or two percent of the total third party Medi-Cal recoveries.

The lack of a third-party field staff causes numerous transfers of case files between the two agencies. This results in delays which may prevent timely identification or recovery, thereby making ultimate collection doubtful. For example, we reviewed one case file in which the

Medi-Cal beneficiary received a $6,000 settlement from a third party. About three months elapsed between the date of settlement and the date the third party unit was informed of the settlement. In the meantime, the beneficiary had spent the money and recovery is considered unlikely by the Department because the beneficiary has no source of income sufficient to reimburse Medi-Cal for some $1,500 in medical costs.

To facilitate identification and collection, staff located near the beneficiary should pursue potential third-party cases so that the case progress can be controlled. This would also reduce administrative costs since both the Health Recovery Bureau and the Third Party Liability Unit are presently engaged in identification and recovery activities. Alternative organizational shifts to improve operation include transferring the third-party activity to the Health Recovery Bureau or creating field offices for the Third Party Liability Unit.

The creation of a field staff for the third party unit would require a staff of an estimated 12 persons at a cost of about $150,000. In addition, if existing Blue Cross or Blue Shield offices could not be utilized, there would be an additional undetermined cost for facilities to house the increased staff. Under this alternative, the existing Health Recovery Bureau staff would remain constant.

However, if the work currently performed by the third party unit is transferred to the field offices of the Health Recovery Bureau, no additional staff would be required (assuming that an equal number of staff

would be required by the Health Recovery Bureau as are presently employed by the third party unit). The benefits of timely identification and recovery are thereby achieved without the $150,000 per year cost of creating a third party unit field collection activity.

CONCLUSION

The inadequate reporting of third-party cases by county welfare departments and liability and workers' insurance carriers, and the duplication of identification and recovery activity by the Third Party Liability Unit and the Health Recovery Bureau, result in additional Medi-Cal administrative costs and lost third-party recoveries.

RECOMMENDATIONS

We recommend that the State Department of Health, in conjunction with the Department of Benefit Payments, determine the costs and benefits of consolidating third-party recovery activities within the Department of Benefit Payments' Health Recovery Bureau or within the Medi-Cal Intermediary Operations. If economically feasible, such a consolidation should be made without delay.

We also recommend that the Department of Benefit Payments:

- Standardize and monitor the reporting procedures used by the county welfare departments for referring third-party cases.

- Pursue administrative or legislative action which will assure timely notification of third-party payments made by casualty and workers' compensation insurance carriers.

BENEFITS

Implementing these recommendations will improve the timeliness of the identification of third-party cases, increase the recovery of Medi-Cal payments made on behalf of beneficiaries who have been injured by a third party and improve the flow of information concerning third-party cases, thereby enabling greater control of these cases.

PROCEDURES TO IDENTIFY MEDI-CAL APPLICANTS AND RECIPIENTS WHO ALREADY POSSESS HEALTH INSURANCE NEED IMPROVEMENT

Section 14124.71 of the Welfare and Institutions Code permits recovery of Medi-Cal payments from the beneficiary's health insurance company. The Health Recovery Bureau of the Department of Benefit Payments is responsible for identifying beneficiaries who have additional health insurance and collecting the reimbursements due the Medi-Cal program.

It is essential for the State to have thorough information concerning beneficiaries who have health insurance in order to obtain the recoveries due the Medi-Cal program. The county welfare departments and the Social Security Administration are the primary sources for this health insurance information.

The Department of Benefit Payments has estimated that the Medi-Cal program spent at least $26 million in fiscal year 1974–75 on services to beneficiaries who already had health insurance policies unknown to the Department. Since health insurance carriers are generally liable for only about 20 to 25 percent of the billed amount, an estimated minimum loss of $5 to $7 million results from inadequate identification of beneficiaries with health insurance.

The following weaknesses exist in the identification of Medi-Cal applicants and beneficiaries who have health insurance:

- County welfare departments do not consistently review responses given by Medi-Cal applicants concerning health insurance.

- Forms to update state information on Medi-Cal beneficiaries who obtain health insurance after initial application are inadequate. In the adult aid programs, we found that there are no forms to convey this information to the State.

- Under state contract, the Social Security Administration is not required to obtain health insurance information from adult aid recipients.

The Review Process of the Medi-Cal Applicants' Responses Concerning Health Insurance Varies Among the Counties

Anyone eligible for family aid is automatically eligible for Medi-Cal. If applicants have health insurance, they must provide information such as the name of the carrier and the policy number. We reviewed nine counties and found that the emphasis given to determining if an applicant had health insurance varied considerably. Four of the counties thoroughly reviewed the responses given by the applicant during the intake review. Two of the counties reviewed the responses only if the applicant had questions. The remaining three counties had substantially no review of health insurance responses.

The Department of Benefit Payments maintains a central identification file from the information required on the applications for aid. The Health Recovery Bureau extracts the names of aid recipients who have indicated they have other health insurance. When the information is incorrect and inadequately reviewed by the county welfare department, the State incurs unnecessary work. For example, the applicant may not record the policy number or proper name of the insurance company. Another delay is caused when the recipient incorrectly records a fire or life insurance policy as health insurance. A thorough quality control review process at the county could help eliminate many of these errors.

The lack of adequate information concerning recipients who have health insurance results in the Medi-Cal program paying for medical services rendered when an insurance carrier is also liable for them.

Due to an Inadequate State Contract, the Social Security Administration Does Not Obtain Health Coverage Information from Adult Aid Applicants

The contract between the State and the Social Security Administration requires the Administration to ask adult aid applicants if they have health insurance. The State, in turn, pays the Social Security Administration 7.5 cents for each applicant questioned at a total cost of approximately $14,000 per year.

If applicants say they have health insurance, they are given a Health Insurance Inquiry form (MC–504) to fill out and return to the Department of Benefit Payments' Health Recovery Bureau. The Social Security Administration distributes over 10,000 health inquiry forms per month.

The Health Recovery Bureau does not have a complete file of adult aid recipients who have health insurance because applicants either fail to return these forms or the information contained on the forms which are returned is erroneous. In order to measure the impact of this condition, we sent questionnaires to a random sample of 500 adult aid recipients drawn from the list of persons whose eligibility was determined by the Social Security Administration. Only about 16 percent of the adult aid recipients who acknowledged having health insurance were reflected in the Health Recovery Bureau records. Health Recovery Bureau officials stated that only 500 to 600 health inquiry forms are received each month. On the basis of our sample, the Bureau should be receiving about 1,500 responses from adult aid recipients per month. This test demonstrates that the current procedures for obtaining health insurance information from adult aid recipients are inadequate.

The information contained on the list received from the Social Security Administration was insufficient to identify the Medi-Cal claims paid. Therefore, we were unable to accurately determine the loss to the Medi-Cal program which results from the failure to recover Medi-Cal

payments from health insurance carriers. However, if the ratio of lost recoveries to unidentified adult aid recipients is similar to the ratio of lost recoveries to all Medi-Cal beneficiaries (including adult aid recipients), there would have been a loss of about $1.5 million during fiscal year 1974–75.

A new contract with the Social Security Administration is necessary before they will provide expanded insurance information. One alternative would be for the Social Security Administration to help the adult aid applicant fill out the health inquiry form to assure that complete and accurate information is obtained. Another alternative would be for the Administration to code the State Data Exchange tape when an adult aid recipient has health insurance. The Health Recovery Bureau could then extract the names of recipients thus coded and mail the Bureau's own questionnaire under a procedure similar to that conducted for family aid recipients.

Means for Reporting Medi-Cal Beneficiaries Who Acquire Health Insurance Subsequent to Initial Application Are Inadequate

Some Medi-Cal beneficiaries acquire health insurance after application to the Medi-Cal program and do not inform the Health Recovery Bureau. For example, a Medi-Cal beneficiary may obtain insurance through new employment and still qualify for low income assistance and therefore qualify for Medi-Cal. Also, children receiving family aid could be entitled to benefits from the absent parent's health

insurance. Occasionally, a Medi-Cal beneficiary may acquire a private policy for health insurance. The methods for reporting these changes in status, however, are inadequate.

A monthly Change in Status Report (WR–7) (see Appendix A) is filed by family aid recipients. This form is used by the counties to record any changes which would affect the beneficiary's eligibility. There is a space on the WR–7 in which health insurance information can be recorded; however, it is under a miscellaneous category of ". . . other information to report," and is inadequate for reporting newly acquired health insurance since the space for reporting insurance information is not prominent. Greater visibility is required to ensure that the Medi-Cal beneficiary's new insurance is adequately recorded and transmitted to the State.

In addition, we found no vehicle for reporting changes in the insurance status of adult aid program recipients. The Social Security Administration is responsible for reexamining these cases on a yearly basis; however, a backlog exists in this procedure and the cases are not being reexamined annually. There are no regulations which would require adult aid recipients to report to the Health Recovery Bureau when they acquire a new health insurance policy.

CONCLUSION

The Medi-Cal program is incurring significant losses due to inadequate procedures regarding recipients who have other health insurance. These inadequacies are demonstrated at the

county level by the lack of review procedures. At the state level, forms to record changes in insurance status are inadequate, as is the contract with the Social Security Administration. At present, the health insurance program operated by the Department of Benefit Payments is unable to obtain complete recoveries due the Medi-Cal program.

RECOMMENDATIONS

We recommend that the Department of Benefit Payments, through its contract with the Department of Health:

- Strengthen the quality control procedures used at the county welfare departments to review health insurance information during the application process.

We also recommend that the Department of Benefit Payments:

- Negotiate a contract with the Social Security Administration to include a code on the State Data Exchange tape which indicates that the adult aid recipient has health insurance.

- Revise Form WR–7 to provide that questions pertaining to changes in insurance status are readily visible.

- Establish regulations which require adult aid recipients to report changes in insurance status.

BENEFITS AND SAVINGS

Implementing these recommendations will improve identification of family and adult aid recipients who have insurance at the time they apply for aid or who obtain insurance subsequent to becoming eligible for aid. This could increase recovery from insurance carriers by a minimum of $5 to $7 million per year.

Respectfully submitted,

JOHN H. WILLIAMS
Auditor General

Date: March 17, 1977

Staff: Kurt R. Sjoberg
B. L. Myers
Linda L. Huffman

DEPARTMENT OF BENEFIT PAYMENTS
744 P Street, Sacramento, CA 95814
916/445-2077

March 16, 1977

Mr. John H. Williams
Auditor General
Joint Legislative Audit Committee
925 L Street, Suite 750
Sacramento, CA 95814

Dear Mr. Williams:

MARCH 1977 DRAFT REPORT: "A MANAGEMENT ANALYSIS OF THE THIRD PARTY LIABILITY AND OTHER HEALTH COVERAGE PROGRAMS"

Since the third party liability and other health coverage recovery functions are the responsibility of both the Department of Health and the Department of Benefit Payments, this response was prepared jointly by both Departments.

Inasmuch as your draft represents an interim report based on preliminary audit findings, we will defer reaching any final conclusions until you have issued your final report. At that time, we will review your recommendations in depth and determine the feasibility of their implementation. However, we would like to briefly respond to the major recommendations and comment on some specific points mentioned in the report.

1. Recommendations on Conclusion One - Page 16

   A. Consolidation of Third Party Recovery Activity

      The Departments agree in general with your recommendation to study the feasibility of consolidating all third party recoveries under the management of the Health Recovery Bureau. The Department of Health's Medi-Cal Procurement Project is reviewing the third party recovery function and is expected to provide preliminary recommendations in the near future.

   B. Standardize and Monitor County Reporting Procedures

      The Departments agree with the recommendation. We will work with the counties to improve reporting procedures.

   C. Initiate Action to Ensure Timely Reporting of Third Party Payments

      The Departments are currently working on a proposal that would require all Medi-Cal providers to indicate Medi-Cal involvement on any bills requested or submitted to insurance carriers.

The Department of Benefit Payments and the Attorney General's staff are working with the Department of Industrial Relations and the Worker Compensation Appeals Board to amend their regulations to permit identification of Medi-Cal involvement prior to adjudication.

2. Recommendations on Conclusion Two - Page 24

A. The Departments have recently completed a study on the reporting of health insurance by counties. Among the study's recommendations is the need for improved reporting and quality control procedures. A pilot project to implement changes is being planned by the Departments.

B. The Commissioner, Social Security Administration, indicated in February 1977 to HEW/SRS that he will not provide additional insurance data to States. However, the two California Departments and Region IX Social Security Administration are adjusting the health insurance coding procedures following an exploration of alternatives. This modification should provide an opportunity to improve the volume and quality of data collection.

C. The Department of Benefit Payments has had a forms revision task group working for several months. Among their responsibilities is revision of the CA-7 (WR-7) form. Your recommendation for revised forms will be considered by the review team.

D. The eligibility of adult aid recipients is determined by the Social Security Administration. Therefore, State regulations requiring beneficiary reporting of health insurance entitlements would not prevail for SSI/SSP cases. However, the eligibility of medically needy and medically indigent persons not covered under Social Security Administration programs is a function of the local welfare department and these reporting requirements are now in effect.

There were some specific points mentioned in the report that we feel need clarification.

* * * 1/

2. On page 5, paragraph 2, the mailing of questionnaires is discussed briefly. These questionnaires are sent to see who may be responsible for an injury and if litigation or other action is being taken by the injured party.

* * * 1/

1/ Comments deleted refer to items shown in draft report but not included in this report.

5. On page 7, several references to collections are made. To be consistent with the maximum stated sum on page 5, the $2.2 million should be $3.86 million, the $90,000 should be $94,000 and the $85,000 should be $420,000.

* * * 1/

10. On page 18, the W&I Code Section 14124.71 citation should be 10020 et seq. In the same paragraph it should be noted that beneficiaries have the responsibility under W&I Code Section 14023 for notifying counties of their legal entitlements and for using them. Additionally, it is the county that is responsible for identification of these assets - not the Health Recovery Bureau.

11. On page 20, the paragraph 1 reference to a 20-25 percent recovery should be modified to a 8-20 percent recovery. The latter figure reflects program experience. The former was from an early study.

12. On page 21, last paragraph, a ratio theory between adult aid and all beneficiaries is incorrectly developed. The adult aid groups have Medicare benefits which materially reduce the Medi-Cal liability.

13. On pages 22-23, the recommendation for change in contract with Social Security Administration is developed. Unfortunately, there are no federal regulations which require SSI/SSP recipients to report their health care entitlements to the Health Recovery Bureau: The State cannot mandate the federal agency and has been unsuccessful in contractually improving the receipt of data.

Thank you for the opportunity to review and comment on your draft report.

Sincerely,

MARION J. WOODS
Director
Department of Benefit Payments

JEROME A. LACKNER, M.D.
Director
Department of Health

1/ Comments deleted refer to items shown in draft report but not included in this report.

NOTE: Page numbers refer to draft report.

MEDI-CAL
INTERMEDIARY OPERATIONS

Two North Point, San Francisco, California 94133

Donald LaNoue
Deputy Executive Director

15 March 1977

John H. Williams, Auditor General
Suite 750, 925 L Street
Sacramento, California 95814

Dear Mr. Williams:

Thank you very much for giving us the opportunity to respond to your draft report "A Management Analysis of the Third Party Liability and Other Health Coverage Programs."

In general, we concur with both the findings and the recommendations contained in this report. I do, however, have a few comments for your consideration for possible inclusion in your final report.

On page 10, you have identified as a weakness which exists in the identification of third party cases and recovery of Medi-Cal payments the lack of an MIO field staff which could pursue recoveries and increase recovery cost. MIO could extend its involvement in the recovery process through the establishment of such a field staff. We would be willing to assume this role on behalf of the State upon receipt of the appropriate directive from the Department of Health.

* * * 1/

1/ Comments deleted refer to items shown in draft report but not included in this report.

BLUE CROSS OF SOUTHERN CALIFORNIA / BLUE CROSS OF NORTHERN CALIFORNIA / BLUE SHIELD OF CALIFORNIA
4777 Sunset Boulevard • Los Angeles, CA 90027 (213) 666–3100 / 1950 Franklin Street • Oakland, CA 94659 (415) 645–3000 / P.O. Box 7924 • San Francisco, CA 94120 (415) 445–5708

* * * 1/

While the consolidation of this function within the Department of Benefit Payments Health Recovery Bureau would probably be of benefit to the Program's administration, the assignment of this consolidated function to MIO might provide even greater benefits. The current referral mechanism which, as is pointed out in the report, may be extremely time consuming would be eliminated. In addition, we believe the assumption that consolidating this function within the Department of Benefit Payments Health Recovery Bureau would not result in additional staff is probably erroneous. In order to identify potential third party liability cases, a portion of the function performed by MIO under existing procedures would need to be retained. This would result in some duplication of effort which could probably be best eliminated by centralizing these activities within the Fiscal Intermediary environment.

There appears, on page 20, an estimation that health insurance carriers are generally liable for only about 20% to 25% of the billed amount. We believe this estimate to be somewhat high. A more appropriate figure might be arrived at by determining the levels at which some of the insurance carriers have now agreed to

1/ Comments deleted refer to items shown in draft report but not included in this report.

settle old claims and are currently processing newly identified health insurance claims being submitted to them by the Department.

Again, thank you for giving us the opportunity to comment on this draft report. I hope our comments may be useful to you in the preparation of your final report to the Joint Legislative Audit Committee.

Sincerely,

Donald LaNoue
Deputy Executive Director
Medi-Cal Intermediary Operations

DL:lg
cc: Charles W. Stewart

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

APPENDIX A

DEPARTMENT OF BENEFIT PAYMENTS

MONTHLY AFDC ELIGIBILITY AND INCOME REPORT

CHANGES TO STATEMENT OF FACTS (WR 2)

THIS REPORT IS FOR THE MONTH OF:

Complete and return this form AFTER THE LAST DAY OF:

This form is needed to redetermine your eligibility and grant amount.

IMPORTANT: FILL THIS FORM OUT COMPLETELY, SIGN, AND MAIL TO THE WELFARE DEPARTMENT, IN THE ENCLOSED STAMPED ENVELOPE. IF THIS FORM IS NOT RETURNED TO THE WELFARE DEPARTMENT BY THE 5TH OF THE MONTH AFTER THE MONTH SHOWN ABOVE, YOU MUST REPORT TO THE OFFICE ADDRESS BELOW FOR A PERSONAL MEETING BY THE 10TH OF THE MONTH AFTER THE MONTH SHOWN ABOVE.

1. I/WE RECEIVED INCOME, MONEY, OR BENEFITS THIS MONTH. ☐ YES ☐ NO

If "Yes," list all income and explain below. Income includes EARNINGS (salary, wages, tips, commissions and bonuses); UNEMPLOYMENT INSURANCE/DISABILITY INSURANCE, workers' compensation, strike benefits, training incentive (CETA); SOCIAL SECURITY/RAILROAD RETIREMENT, supplemental security income (SSI), pensions, business, farm, rental; CHILD SUPPORT, contributions (UAM, stepfather, others), free housing/utilities/food/clothing; MILITARY BENEFITS, settlements, tax refunds, loans and grants, gifts, and any other money you receive.

WHO RECEIVED INCOME, MONEY, OR BENEFITS	SOURCE OF INCOME, MONEY, OR BENEFITS (if earnings, list employer)	DATE(S) RECEIVED	AMOUNT ($) (before deductions)
			$
			$
			$
			$
			$
			$

If anyone who received income above PAID support under court order this month, indicate the **AMOUNT ($)**_____

WORK EXPENSES: COMPLETE FOR EARNED INCOME ONLY.

(If you are self-employed, attach a separate sheet of paper, if needed, and explain your business expenses.)

PERSON CLAIMING EXPENSES	TAX EXEMPTIONS CLAIMED	DAYS WORKED	HOURS WORKED	TRANSPORTATION EXPENSES				CHILD CARE EXPENSE (ATTACH RECEIPTS)	OTHER WORK EXPENSES ADDITIONAL FOOD, CLOTHING, OR PERSONAL INCIDENTALS, TOOLS, LICENSES, MATERIALS OR UNION DUES	
				METHOD (CAR, CARPOOL, BUS, ETC.)	DAYS USING THIS METHOD	DAILY COST ROUND TRIP	DAILY MILES ROUND TRIP		(ATTACH RECEIPTS)	AMOUNT
								$		$
								$		$
								$		$
								$		$

YOU MUST SEND ALL PAY STUBS FOR EARNED INCOME WITH THIS FORM.

COUNTY USE ONLY

WR 7 (2/76)

2. I/WE HAD CHANGES IN THE HOUSEHOLD OR FAMILY THIS MONTH. ☐ YES ☐ NO

If "Yes," explain below, including someone who moved in or out of your home, entered or left a hospital or other public or private institution (foster home, juvenile hall, jail), married, became pregnant, gave birth or otherwise terminated pregnancy, started, refused, lost or quit a job or job training, became unemployed, recovered from or became disabled, or died.

PERSON AFFECTED	RELATIONSHIP	AGE	ACTION (OR WHAT CHANGED)	DATE

3. I/WE HAVE CHILDREN 16–20 LIVING IN THE HOME. ☐ YES ☐ NO

If "Yes," *list* each child and explain below.

NAME	AGE	Regularly Attending School or Training Program (list name of school or program)	Units/Hours per week	Explain Employment Status If Child Is Not Attending School or Training

4. I/WE HAD A CHANGE IN REAL OR PERSONAL PROPERTY THIS MONTH. ☐ YES ☐ NO

A. Explain below any change in cash, checking or savings account, safe deposits, stocks, or other (liquid) assets such as bonds, notes, sales contracts, mortgages, or trust deeds. List the **total** current value of each item that changed during the month.

B. Explain below any change (bought, sold, received or transferred) in houses or land; campers, boats or trailers, jewelry, musical instruments, recreation equipment, other equipment or material, livestock or fowl (not for family use); motor vehicles; appliances (not built in as part of the house), T.V., radio, phonograph, tape recorder, any power equipment (garden, cleaning, tools), essential household items; future burial/funeral arrangements, life and burial insurance, or other personal property. If you bought an item, show how much you now owe on it in the "Reason for Change/Amount Owed" column.

ITEM	WHAT HAPPENED	REASON FOR CHANGE/AMOUNT OWED	DATE	CURRENT VALUE

5. I/WE HAVE OTHER INFORMATION TO REPORT. ☐ YES ☐ NO

"If "Yes," explain below. Include new address, telephone, medical/health insurance; changes in housing or utilities costs and YOUNGEST CHILD HAVING 6TH BIRTHDAY NEXT MONTH. Also include information on the identity or whereabouts of an absent parent(s).

SHOW ANY EXPECTED CHANGES IN YOUR HOUSEHOLD, EMPLOYMENT, INCOME OR PROPERTY NEXT MONTH.

AFTER ANSWERING ALL QUESTIONS, YOU, AND YOUR SPOUSE OR OTHER PARENT OF THE CHILD(REN) LIVING IN THE HOME, MUST SIGN THE FORM. IF YOU MAKE A MARK, A WITNESS MUST ALSO SIGN BELOW. AN INTERPRETER OR SOMEONE COMPLETING THIS FORM FOR YOU MUST ALSO SIGN. WITHHOLDING OF INFORMATION OR MISREPRESENTATION OF FACT CAN RESULT IN LEGAL PROSECUTION WHEN SIGNED UNDER PENALTY OF PERJURY.
I UNDERSTAND THAT I MUST CONTACT MY ELIGIBILITY WORKER IMMEDIATELY AND REPORT ANY UNEXPECTED CHANGE THAT OCCURS OR IF I HAVE ANY DOUBT ABOUT NEEDING TO REPORT ANY CHANGE.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT

SIGNATURE (OR MARK)	DATE SIGNED	TELEPHONE
SIGNATURE OF SPOUSE OR OTHER PARENT LIVING IN THE HOME	MAILING ADDRESS (NUMBER, STREET, CITY, ZIP)	
SIGNATURE OF WITNESS, INTERPRETER, OR PERSON COMPLETING FORM FOR RECIPIENT	HOME ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)	

IF ANY UNEXPECTED CHANGES OCCUR, YOU STILL MUST CONTACT YOUR ELIGIBILITY WORKER IMMEDIATELY.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps